DEPARTMENT OF PUBLIC HEALTH
AND HUMAN SERVICES

CHAPTER 85

GENERAL MEDICAID SERVICES

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Miscellaneous

37.85.201 SELECTION OF PROVIDER (1) Except as otherwise provided in ARM Title 37, chapters 40, 80, 82, 83, 85, 86, 88 any individual eligible for medical assistance may obtain the services available from any institution, agency, pharmacy, or practitioner, qualified to perform such services and participating under the program, including an organization which provides these services or arranges for their availability on a prepayment basis. (History: Sec. 53-2-201 and 53-6-113, MCA; IMP, Sec. 53-6-116 and 53-6-132, MCA; NEW, Eff. 11/4/74; AMD, Eff. 11/3/75; AMD, 1982 MAR p. 729, Eff. 4/16/82; AMD, 1997 MAR p. 548, Eff. 3/25/97; AMD, 1999 MAR p. 1301, Eff. 7/1/99; TRANS, from SRS, 2000 MAR p. 479.)

Rules 02 and 03 reserved

37.85.204 RECIPIENT REQUIREMENTS, COST SHARING

(1) Except as provided in (4) through (6) each recipient must pay to the provider a copayment of $100 per discharge for inpatient hospital services, not to exceed the cost of the services.

(2) Except as provided in (4) through (6) each recipient must pay to the provider a cost sharing payment for outpatient drugs not to exceed the cost of the service. The rate of cost sharing payment is a minimum of $1 per prescription up to a maximum of $5 per prescription based on 5% of the medicaid allowed amount. The maximum total cost sharing payment per recipient for outpatient drugs shall not exceed $25 per month.

(3) Except as provided in (4) through (6) each recipient must pay to the provider a cost sharing payment not to exceed the cost of the service. For the following service providers, the rate of cost sharing is a minimum of $1 per visit up to a maximum of the lesser of $5 per visit or 5% of the average medicaid allowed amount for that provider type, rounded to the nearest dollar:

(a) outpatient hospital services;
(b) podiatry services;
(c) physical therapy services;
(d) speech therapy services;
(e) audiology services;
(f) hearing aid services;
(g) occupational therapy services;
(h) home health services;
(i) ambulatory surgical center services;
(j) public health clinic services;
(k) dental services;
(l) denturist services;
(m) durable medical equipment, orthotics, prosthetics, and medical supplies;
(n) optometric and optician services;
(o) physician services;
(p) mid-level practitioner services;
(q) federally qualified health center services;
(r) rural health clinic services;
(s) freestanding dialysis clinic services;
(t) licensed psychiatrist services;
(u) licensed psychologist services;
(v) licensed clinical social worker services;
(w) licensed professional counselor services;
(x) independent diagnostic testing facility services; and
(y) home infusion therapy services.

(4) For purposes of this rule, "medicaid allowed amount" means the amount allowed in accordance with the reimbursement methodology for the particular service, before third party liability, incurment and other such payments are applied.

(5) The following individuals are exempt from cost sharing:

(a) individuals under 21 years of age;

(b) pregnant women; and

(c) institutionalized individuals for services furnished to any individual who is an inpatient in a hospital, skilled nursing facility, intermediate care facility or other medical institution if such individual is required to spend for the cost of care all but their personal needs allowance, as defined in ARM 37.82.1320.

(6) Cost sharing may not be charged for services provided for the following purposes:

(a) emergencies;

(b) family planning;

(c) hospice;

(d) personal assistance services;

(e) home dialysis attendant services;

(f) home and community based waiver services;

(g) non-emergency medical transportation services;

(h) eyeglasses purchased by the medicaid program under a volume purchasing arrangement;

(i) early and periodic screening, diagnostic and treatment (EPSDT) services;

(j) independent laboratory and x-ray services;

(k) services for medicare crossover claims where medicaid is the secondary payor under ARM 37.85.406(18). If a service is not covered by medicare but is covered by medicaid, cost sharing will be applied; and

(l) services for third party liability (TPL) claims where medicaid is the secondary payor under ARM 37.85.407. If a service is not covered by TPL but is covered by medicaid, cost sharing will be applied. (History: Sec. 53-2-201 and 53-6-113, MCA; IMP, Sec. 53-6-101, 53-6-113 and 53-6-141, MCA; NEW, 1983 MAR p. 1197, Eff. 8/26/83; AMD, 1986 MAR p. 677, Eff. 4/25/86; AMD, 1987 MAR p. 895, Eff. 7/1/87; AMD, 1987 MAR p. 1688, Eff. 10/1/87; AMD, 1988 MAR p. 758, Eff. 4/15/88; AMD, 1989 MAR p. 272, Eff. 3/1/89; AMD, 1989 MAR p. 859, Eff. 6/30/89; AMD, 1989 MAR p. 842, Eff. 7/1/89; AMD, 1994 MAR p. 686, Eff. 4/1/94; AMD, 1995 MAR p. 1159, Eff. 7/1/95; AMD, 1997 MAR p. 548, Eff. 3/25/97; AMD, 1997 MAR p. 1208, Eff. 7/8/97; AMD, 1999 MAR p. 1301, Eff. 7/1/99; TRANS, from SRS, 2000 MAR p. 479; AMD, 2002 MAR p. 797, Eff. 3/15/02; EMERG, AMD, 2002 MAR p. 3156, Eff. 11/15/02.)

37.85.205 RECIPIENT RESTRICTION OF ACCESS TO MEDICAL SERVICES (REPEALED) (History: Sec. 53-6-113, MCA; IMP, Sec. 53-6-104, MCA; NEW, 1979 MAR p. 1122, Eff. 9/28/79; AMD, 1983 MAR p. 354, Eff. 4/29/83; AMD, 1985 MAR p. 249, Eff. 3/15/85; TRANS & AMD, from SRS, 2000 MAR p. 1653, Eff. 6/30/00; REP, 2004 MAR p. 1624, Eff. 7/23/04.)

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37.85.206 SERVICES PROVIDED (1) Except as otherwise provided in this rule, the following medical or remedial care and services shall be available to all persons who are certified eligible for medicaid benefits under this chapter (including deceased persons, categorically related, who would have been eligible had death not prevented them from applying). However, only those medical or remedial care and services also covered by medicare shall be available to a person who is certified eligible for medicaid benefits as a qualified medicare beneficiary under ARM 37.83.201 and 37.83.202.

(a) inpatient hospital services;
(b) outpatient hospital services;
(c) non-hospital laboratory and x-ray services;
(d) nursing facility services;
(e) early and periodic screening, diagnosis and treatment services;
(f) physician's services;
(g) podiatry services;
(h) outpatient physical therapy services;
(i) speech therapy, audiology and hearing aid services;
(j) outpatient occupational therapy services;
(k) home health care services;
(l) personal care services in a recipient's home;
(m) home dialysis services;
(n) private duty nursing services;
(o) clinic services;
(p) dental services;
(q) outpatient drugs;
(r) durable medical equipment, prosthetic devices and medical supplies;
(s) eyeglasses and optometric services;
(t) transportation and per diem;
(u) ambulance services;
(v) specialized non-emergency transportation;
(w) family planning services;
(x) home and community services;
(y) mid-level practitioner services;
(z) hospice services;
(aa) licensed psychologist services;
(ab) licensed clinical social worker services;
(ac) licensed professional counselor services;
(ad) inpatient psychiatric services;
(ae) mental health center services;
(af) case management services;
(ag) institutions for mental diseases for persons age 65 and over; and
(ah) payment of premiums, co-insurance, deductibles and other cost sharing obligations under an individual or group health plan in accordance with the provisions of ARM 37.82.424.

(2) Individuals who are recipients of assistance in the pathways, community services or job supplement components of the families achieving independence in Montana (FAIM) project and who are 21 years of age or older and all recipients of AFDC-related medical assistance only who are participating in the FAIM project and are 21 years of age or older will receive basic medicaid benefits, except that pregnant women will be entitled to all services specified in (1)(a) through (1)(ah) of this rule. Basic medicaid benefits are the services specified in (1)(a) through (1)(ah) of this rule except the following:

(a) eyeglasses and routine eye exams, whether provided by an optometrist, ophthalmologist or other provider;

(b) audiology and hearing aids;

(c) personal care services in the recipient's home;

(d) dental services; and

(e) durable medical equipment and supplies.

(3) With regard to persons identified in (2) who receive basic medicaid benefits, the department will provide the noncovered services specified in (2)(a) through (2)(e):

(a) if the noncovered services are required as a condition of employment; or

(b) on an emergency basis. For purposes of this rule, an emergency is a situation which:

(i) arises suddenly or unexpectedly; and

(ii) is life-threatening or has very serious implications for the individual's health. (History: Sec. 53-2-201 and 53-6-113, MCA; IMP, Sec. 53-2-201, 53-6-101, 53-6-103, 53-6-111, 53-6-113, 53-6-131 and 53-6-141, MCA; NEW, 1980 MAR p. 1789, Eff. 6/27/80; AMD, 1986 MAR p. 677, Eff. 4/25/86; AMD, 1987 MAR p. 895, Eff. 7/1/87; AMD, 1987 MAR p. 1688, Eff. 10/1/87; AMD, 1988 MAR p. 758, Eff. 4/15/88; AMD, 1988 MAR p. 2228, Eff. 10/14/88; AMD, 1989 MAR p. 835, Eff. 6/30/89; AMD, 1989 MAR p. 842, Eff. 7/1/89; AMD, 1991 MAR p. 1021, Eff. 6/28/91; AMD, 1992 MAR p. 1401, Eff. 6/26/92; AMD, 1994 MAR p. 313, Eff. 2/11/94; AMD, 1996 MAR p. 284, Eff. 1/26/96; AMD, 1997 MAR p. 474, Eff. 3/11/97; AMD, 1997 MAR p. 898, Eff. 3/25/97; AMD, 1999 MAR p. 1806, Eff. 7/1/99; TRANS, from SRS, 2000 MAR p. 479.)

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37.85.207 SERVICES NOT PROVIDED BY THE MEDICAID PROGRAM

(1) Items or medical services not specifically included within these rules as covered benefits of the Montana medicaid program are not reimbursable.

(2) The following medical and nonmedical services are explicitly excluded from the Montana medicaid program except for those services covered under the health care facility licensure rules of the Montana department of public health and human services when provided as part of a prescribed regimen of care to an inpatient of a licensed health care facility, except for those services specifically available, as listed in ARM 37.40.1406, to persons eligible for home and community-based services; and except for those medicare covered services, as listed in ARM 37.83.812 to qualified medicare beneficiaries for whom the Montana medicaid program pays the medicare premiums, deductible and coinsurance:

(a) chiropractic services;

(b) acupuncture services;

(c) naturopathic services;

(d) dietician services;

(e) physical therapy aide services, except as provided in ARM 37.86.601, 37.86.605, 37.86.606, 37.86.610 and 46.12.529;

(f) surgical technicians who are not physicians or mid-level practitioners;

(g) nutritional services;

(h) masseur or masseuse services;

(i) dietary supplements;

(j) homemaker services;

(k) telephone service in home, remodeling of home, plumbing service, car repair and/or modification of automobile;

(l) delivery services not provided in a licensed health care facility unless as an emergency service. Delivery services means services necessary to protect the health and safety of the woman and fetus from the onset of labor through delivery. Emergency service is defined in ARM 37.82.102;

(m) treatment services for infertility, including sterilization reversals;

(n) experimental services;

(o) all gastric bypass related services (including initial bypass and revisions); and

(p) circumcisions not authorized by the department as medically necessary.

(3) Effective February 1, 2003, until June 30, 2003, the following services will no longer be covered for individuals age 21 and over:

(a) audiology;

(b) eyeglasses;

(c) routine eye exams provided by optometrists and ophthalmologists;

(d) hearing aids;

(e) orthotic devices;

(f) prosthetic devices;

(g) dental, excluding emergency services for the treatment of pain; and

(h) denturist.

(4) Medical services furnished to medicaid eligible recipients who are absent from the state are excluded from the Montana medicaid program except for those medical services provided when:

(a) there is a medical emergency and the recipient's health would be endangered if he were required to travel to Montana to obtain the medical services;

(b) the recipient travels to another state because the department finds the required medical services are not available in Montana; or it is determined by the department that it is general practice for recipients in a particular locality to use medical resources in another state;

(c) the recipient or his representative can demonstrate to the satisfaction of the department that out-of-state medical services and all related expenses will be less costly than in-state services; or

(d) the recipient is a child residing in another state for whom Montana makes adoption assistance or foster care maintenance payments. (History: Sec. 53-2-201, 53-6-113 and 53-6-402, MCA; IMP, Sec. 53-2-201, 53-6-101, 53-6-103, 53-6-116, 53-6-131, 53-6-141 and 53-6-402, MCA; NEW, 1980 MAR p. 1793, Eff. 6/27/80; AMD, 1983 MAR p. 863, Eff. 7/15/83; AMD, 1985 MAR p. 250, Eff. 3/15/85; AMD, 1986 MAR p. 677, Eff. 4/25/86; AMD, 1987 MAR p. 895, Eff. 7/1/87; AMD, 1987 MAR p. 1688, Eff. 10/1/87; AMD, 1988 MAR p. 758, Eff. 4/15/88; AMD, 1988 MAR p. 1255, Eff. 7/1/88; AMD, 1989 MAR p. 835, Eff. 6/30/89; AMD, 1992 MAR p. 1401, Eff. 6/26/92; AMD, 1997 MAR p. 474, Eff. 3/11/97; AMD, 1997 MAR p. 548, Eff. 3/25/97; AMD, 1999 MAR p. 1301, Eff. 7/1/99; TRANS, from SRS, 2000 MAR p. 479; EMERG, AMD, 2003 MAR p. 999, Eff. 5/9/03.)

Rules 08 through 11 reserved

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37.85.212 RESOURCE BASED RELATIVE VALUE SCALE (RBRVS) REIMBURSEMENT FOR SPECIFIED PROVIDER TYPES (1) For purposes of this rule, the following definitions apply:

(a) "Anesthesia units" means time and base units used to compute reimbursement under RBRVS for anesthesia services. Base units are those units as defined by the medicare program. Time units are 15 minute intervals during which anesthesia is provided.

(b) "Conversion factor" means a dollar amount by which the relative value units, or the base and time units for anesthesia services, are multiplied in order to convert the relative value units to a fee for a service.

(c) "Policy adjustor" means a factor by which the product of the relative value units and the conversion factor is multiplied to increase or decrease the fees paid by medicaid for certain categories of services.

(d) "Provider's invoice cost" means the actual dollar amount paid by a medicaid provider for a specific item of durable medical equipment (DME) or supply. It does not include any markup added by the provider.

(e) "Relative value unit (RVU)" means a numerical value assigned in the resource based relative value scale to each procedure code used to bill for services provided by a health care provider. The relative value unit assigned to a particular code expresses the relative effort and expense expended by a provider in providing one service as compared with another service.

(f) "Resource based relative value scale (RBRVS)" means the most current version of the medicare resource based relative value scale contained in the physicians' medicare fee schedule adopted by the centers for medicare and medicaid services (CMS) of the U.S. department of health and human services and published at 69 Federal Register 66235 (November 15, 2004), effective January 1, 2005 which is adopted and incorporated by reference. A copy of the medicare fee schedule may be obtained from the Department of Public Health and Human Services, Health Resources Division, 1400 Broadway, P.O. Box 202951, Helena, MT 59620-2951. The RBRVS reflects RVUs for estimates of the actual effort and expense involved in providing different health care services.

(g) "Subsequent surgical procedure" means any additional surgical procedure or service, except for add-ons and modifier 51 exempt codes, performed after a primary operation in the same operative session.

(h) "Usual and customary" means those charges that the medicaid provider would charge for a particular service in a majority of cases including medicaid and nonmedicaid patients.

(2) Services provided by the following health care professionals will be reimbursed in accordance with the RBRVS methodology set forth in (3):

(a) physicians;
(b) mid-level practitioners;
(c) podiatrists;
(d) physical therapists;
(e) occupational therapists;
(f) speech therapists;
(g) audiologists;
(h) optometrists;
(i) opticians;
(j) providers of clinic services;
(k) providers of EPSDT services;
(l) licensed psychologists;
(m) licensed clinical social workers;
(n) licensed professional counselors;
(o) dentists providing medical services;
(p) providers of oral surgery services;
(q) providers of pathology and laboratory services;
(r) independent diagnostic testing facilities (IDTF); and
(s) school based services.

(3) Except as set forth in (8), (9), (10) and (11) the fee for a covered service provided by any of the provider types specified in (2) is determined by multiplying the RVUs determined in accordance with (7) by the conversion factor, which is required to achieve the overall budget appropriation for physician services in House Bill 2 of the 2005 legislative session (the General Appropriations Act of 2005) and then multiplying the product by a factor of one plus or minus the applicable policy adjustor as provided in (4) or (5), if any.

(4) The reimbursement increases will be effective as follows:

(a) On July 1, 2005:

(i) $1,233,000 will be applied to maternity related services;

(ii) $3,448,000 will be applied to physician related services, that is, those procedures priced by RBRVS and performed by a physician, mid-level practitioner, podiatrist, independent diagnostic testing facility (IDTF), or public health clinic.

(b) On January 1, 2006, $324,500 additional total funds will be applied to well child preventive visits.

(c) Policy adjustors will be used to accomplish the funding allocations in (4)(a) and (b).

(5) A policy adjustor of up to 10% may be applied to family planning services.

(a) The department's list of specific maternity related services and family planning services as amended through January 1, 2005 is adopted and incorporated by reference. A copy of the list is available on request from the Department of Public Health and Human Services, Health Resources Division, 1400 Broadway, P.O. Box 202951, Helena, MT 59620-2951.

(6) The RVUs for most services are adopted from the resource based RBRVS. For most services for which the RBRVS does not specify RVUs, the department sets those RVUs.

(7) The RVUs for a medicaid covered service provided by any of the provider types specified in (2) are calculated as follows:

(a) if medicare sets RVUs, the medicare RVUs are applicable;

(b) if medicare does not set RVUs but medicaid sets RVUs, the medicaid RVUs are set in the following manner:

(i) convert the existing dollar value of a fee to an RVU value;

(ii) evaluate the RVU of similar services and assign an RVU value; or

(iii) convert the average by report dollar value of a fee to an RVU value.

(8) Except for physician administered drugs as provided in ARM 37.86.105(3), clinical, laboratory services and anesthesia services, if neither medicare nor medicaid sets RVUs, then reimbursement is by report.

(a) Through the by report methodology the department reimburses a percent of the provider's usual and customary charges for a procedure code where no fee has been assigned. The percentage is determined by dividing the previous state fiscal year's total medicaid reimbursement for RBRVS provider covered services by the previous state fiscal year's total medicaid billings.

(b) For state fiscal year 2006, the by report rate is 43% of the provider's usual and customary charges.

(9) For clinical laboratory services for which there is an established fee:

(a) the department pays the lower of the following for procedure codes with fees:

(i) the provider's usual and customary charges for the service; or

(ii) 60% of the medicare fee schedule for physician offices and independent labs and hospitals functioning as independent labs; or

(iii) the established medicaid fee.

(b) for clinical laboratory services for which there is no established fee, the department pays the lower of the following for procedure codes without fees:

(i) the provider's usual and customary charges for the service;

(ii) the rate established using the by report methodology; or

(A) for purposes of (9)(b) through (9)(b)(iii), the by report methodology means averaging 50 paid claims for the same code that have been submitted within a 12 month span and then multiplying the average by the amount specified in (8)(b).

(iii) the historical comparative value of the procedure as indicated by the reimbursement amount paid by medicaid and other third party payors for the same procedure within the last 12 months.

(10) For anesthesia services the department pays the lower of the following for procedure codes with fees:

(a) the provider's usual and customary charges for the service;

(b) a fee determined by multiplying the anesthesia conversion factor by the sum of the applicable base and time units, and then multiplying the product by a factor of one plus or minus the applicable policy adjustor, if any;

(c) the department pays the lower of the following for procedure codes without fees:

(i) the provider's usual and customary charges for the services; or

(ii) the by report rate.

(11) For equipment and supplies:

(a) the department pays the lower of the following for durable medical equipment (DME) items with fees:

(i) the provider's invoice cost for the DME; or

(ii) the medicaid fee schedule as provided in ARM 37.86.1807.

(b) the department pays the lower of the following for DME items without fees:

(i) the provider's invoice cost for the DME; or

(ii) the by report rate provided in (8)(b).

(c) except for the bundled items as provided in (13), the department pays the lower of the following for supply items with fees:

(i) the provider's invoice cost for the supply item; or

(ii) the medicaid fee schedule as provided in ARM 37.86.1807.

(d) except for bundled items as provided in (13), the department pays the lower of the following for supply items without fees:

(i) the provider's invoice cost for the supply item; or

(ii) the by report rate provided in (8)(b).

(12) Subject to the provisions of (12)(a), when billed with a modifier, payment for procedures established under the provisions of (7) is a percentage of the rate established for the procedures.

(a) The methodology to determine the specific percent for each modifier is as follows:

(i) The department obtains information from medicare and other third party payers regarding the comparative value utilized for payment of procedures billed with modifiers.

(ii) The department establishes a specific percentage for each modifier based upon the purpose of the modifier, the comparative value of the modified service and the medical insurance industry trend of reimbursement for the modifier.

(iii) The department's list of the specific percents for the modifiers used by medicaid as amended through January 1, 2005 is adopted and incorporated by reference. A copy of the list is available on request from the Department of Public Health and Human Services, Health Resources Division, 1400 Broadway, P.O. Box 202951, Helena, MT 59620-2951.

(iv) Notwithstanding any other provision, procedure code modifiers "80", "81", "82", and "AS", used by assistant surgeons shall be reimbursed at 16% of the department's fee schedule.

(v) Notwithstanding any other provision, procedure code modifier "62" used by cosurgeons shall be reimbursed at 62.5% of the department's fee schedule for each cosurgeon.

(vi) Notwithstanding any other provision, subsequent surgical procedures shall be reimbursed at 50% of the department's fee schedule.

(13) In applying the RBRVS methodology set forth in this rule, medicaid reimburses in accordance with medicare's policy on the bundling of services, as set forth in the physicians' medicare fee schedule adopted by CMS and published in the Federal Register annually, whereby payment for certain services constitutes payment for certain other services which are considered to be included in those services.

(14) Providers must bill for services using the procedure codes and modifiers set forth, and according to the definitions contained in the federal health care administration's common procedure coding system (HCPCS). Information regarding billing codes, modifiers and HCPCS is available upon request from the health resources division at the address previously stated in this rule. (History: Sec. 53-2-201 and 53-6-113, MCA; IMP, Sec. 53-2-201, 53-6-101, 53-6-111 and 53-6-113, MCA; NEW, 1997 MAR p. 1269, Eff. 7/22/97; AMD, 1998 MAR p. 676, Eff. 3/13/98; AMD, 1998 MAR p. 2168, Eff. 8/14/98; AMD, 1999 MAR p. 1301, Eff. 7/1/99; AMD, 1999 MAR p. 1379, Eff. 7/1/99; TRANS, from SRS, 2000 MAR p. 479; AMD, 2000 MAR p. 1664, Eff. 6/30/00; AMD, 2001 MAR p. 984, Eff. 6/8/01; EMERG, AMD, 2002 MAR p. 797, Eff. 3/15/02; AMD, 2002 MAR p. 1775, Eff. 6/28/02; EMERG, AMD, 2002 MAR p. 2665, Eff. 9/27/02; AMD, 2002 MAR p. 3637, Eff. 12/27/02; EMERG, AMD, 2003 MAR p. 1311, Eff. 7/1/03; AMD, 2004 MAR p. 1488, Eff. 7/2/04; AMD, 2005 MAR p. 974, Eff. 7/1/05.)

Rules 13 through 19 reserved

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37.85.220 INDEPENDENT DIAGNOSTIC TESTING FACILITIES

(1) Any facility that is enrolled in the federal medicare program as an independent diagnostic testing facility (IDTF) may also enroll in the Montana medicaid program as an IDTF.

(2) IDTFs enrolled in the Montana medicaid program shall be governed by 42 CFR 410.32 and 410.33. The department hereby adopts and incorporates by reference 42 CFR 410.32 and 410.33 (2001). Copies of 42 CFR 410.32 and 410.33 (2001) are available upon request from the Department of Public Health and Human Services, Health Policy and Services Division, 1400 Broadway, P.O. Box 202951, Helena, MT 59620-2951.

(3) In addition to 42 CFR 410.32 and 410.33, IDTFs enrolled in the Montana medicaid program shall comply with all rules generally applicable to medicaid providers.

(4) An IDTF shall be reimbursed for diagnostic services performed pursuant to this rule in accordance with ARM 37.85.406 and 37.86.105.

(5) The IDTFs enrolled in the Montana medicaid program shall also be governed by the IDTF Provider Manual dated January 2002. The department hereby adopts and incorporates by reference the IDTF Provider Manual. Copies of the IDTF Provider Manual are available upon request at the address specified in (2). (History: Sec. 53-6-113, MCA; IMP, Sec. 53-6-111, MCA; NEW, 2002 MAR p. 797, Eff. 3/15/02.)

Subchapter 3 reserved

Subchapter 4

Provider Requirements

37.85.401 PROVIDER PARTICIPATION (1) As a condition of participation in the Montana medicaid program all providers must comply with all applicable state and federal statutes, rules and regulations, including but not limited to federal regulations and statutes found in Title 42 of the Code of Federal Regulations and the United States Code governing the medicaid program and all applicable Montana statutes and rules governing licensure and certification. (History: Sec. 53-6-113, MCA; IMP, Sec. 53-2-201, 53-6-101, 53-6-111, 53-6-113 and 53-6-141, MCA; NEW, 1980 MAR p. 1491, Eff. 5/16/80; AMD, 1997 MAR p. 474, Eff. 3/11/97; TRANS, from SRS, 2000 MAR p. 479.)

37.85.402 PROVIDER ENROLLMENT AND AGREEMENTS

(1) Providers must enroll in the Montana medicaid program for each category of services to be provided. As a condition of granting enrollment approval or of allowing continuing enrollment, the department may require the provider to:

(a) complete and submit an enrollment application or form;

(b) complete and submit agreements or other forms applicable to the provider's category of service;

(c) provide information and documentation regarding ownership and control of the provider entity and regarding the provider's ownership interest or control rights in other providers that bill medicaid;

(d) provide information and documentation regarding:

(i) any sanctions, suspensions, exclusions or civil monetary penalties imposed by the medicare program, any state medicaid program or other federal program against the provider, a person or entity with an ownership or control interest in the provider or an agent or managing employee of the provider; and

(ii) any criminal charges brought against and any criminal convictions of the provider, a person or entity with an ownership or control interest in the provider or an agent or managing employee of the provider related to that person’s or entity's involvement in medicare, medicaid or the Title XX services program; and

(e) submit documentation and information demonstrating compliance with participation requirements applicable to the provider's category of service.

(2) Providers shall provide the department's fiscal agent with 30 days advance written notice of any change in the provider's name, address, tax identification number, group practice arrangement, business organization or ownership.

(a) An enrolled provider is not entitled to change retroactively the category of service for which the provider is enrolled, but must enroll prospectively in the new program category. The change in service category will be effective only upon approval of a completed enrollment application for the new service category and on or after the effective date of all required licenses and certifications. The change will apply only to services provided on or after the effective date of the enrollment change.

(3) Except as provided in (2)(a), an approved enrollment is effective on the later of:

(a) 1 year prior to the date the completed enrollment application is received by the department's fiscal agent; or

(b) the date as of which all required licenses and certifications are effective.

(4) Providers, whose services are covered by the Title XVIII program (medicare), shall meet the certification standards of medicare except as provided otherwise in these rules.

(5) Providers shall render services to an eligible medicaid recipient in the same scope, quality, duration and method of delivery as to the general public, unless specifically limited by these regulations.

(a) No provider may deny services to any recipient because of the recipient's inability to pay a copayment in ARM 37.83.826 or in ARM 37.85.204.

(6) Providers shall not discriminate illegally in the provision of service to eligible medicaid recipients or in employment of persons on the grounds of race, creed, religion, color, sex, national origin, political ideas, marital status, age or disability. Providers shall comply with the Civil Rights Act of 1964 (42 USC 2000d, et seq.), The Age Discrimination Act of 1975 (42 USC 6101, et seq.), The Americans With Disabilities Act of 1990 (42 USC 12101, et seq.), section 504 of the Rehabilitation Act of 1973 (29 USC 794), and the applicable provisions of Title 49, MCA, as amended and all regulations and rules implementing the statutes. (History: Sec. 53-2-201 and 53-6-113, MCA; IMP, Sec. 53-2-201, 53-6-101, 53-6-111, 53-6-113, 53-6-131 and 53-6-141, MCA; NEW, 1980 MAR p. 1491, Eff. 5/16/80; AMD, 1983 MAR p. 1197, Eff. 8/26/83; AMD, 1987 MAR p. 900, Eff. 6/30/87; AMD, 1987 MAR p. 1116, Eff. 7/17/87; AMD, 1989 MAR p. 835, Eff. 6/30/89; AMD, 1997 MAR p. 474, Eff. 3/11/97; TRANS, from SRS, 2000 MAR p. 479.)

Rules 03 through 05 reserved

37.85.406 BILLING, REIMBURSEMENT, CLAIMS PROCESSING, AND PAYMENT (1) Providers must submit clean claims to medicaid within the latest of:

(a) 12 months from the latest of:

(i) the date of service;

(ii) the date retroactive eligibility is determined; or

(iii) the date disability was determined;

(b) six months from the date on the medicare explanation of benefits approving the service, if the medicare claim was timely filed and the recipient was medicare eligible at the time the medicare claim was filed; or

(c) six months from the date on an adjustment notice from a third party payor, where the third party payor has previously processed the claim for the same service and the adjustment notice is dated after the periods described in (1)(a) and (b).

(2) For purposes of this rule:

(a) "Clean claim" means a claim that can be processed without additional information or documentation from or action by the provider of the service;

(b) For inpatient hospital services, date of service is the date of discharge;

(c) The date of submission to the medicaid program is the date the claim is stamped "received" by the department or its designee; and

(d) The claim submission deadline specified in (1) through (1)(c) applies regardless of whether or not a third party has allowed or denied a provider's claim. If a third party has not allowed or denied a provider's claim, the provider may submit a claim to medicaid according to the requirements of ARM 37.85.407(6)(c) and subject to the claim submission deadline specified in (1) through (1)(c).

(3) Claims must be submitted in accordance with this rule to be valid. In processing claims, the department or its agent may deny payment of or pend a claim upon determining that a basis exists for denial of payment or pending the claim. No further review or processing of a denied claim is required until resubmission of the claim by the provider. The department or its agent is not required to list or identify all possible grounds for denial or pending of the claim. The fact that a particular basis for denial or pending of a claim for a service or item was not identified on an earlier statement of remittance or other similar statement does not preclude denial or pending of the claim on that basis on a later submission of the claim.

(4) Except as provided in (7) of this rule, all medicaid claims submitted to the department are to be submitted on a state claim form which is:

(a) personally signed by that provider;

(b) personally signed by a person who has actual written authority to bind and represent the provider for this purpose. The department may require a provider to furnish this written authorization; or

(c) signed by the use of a facsimile signature stamp or a computer generated, typed or block letter signature. Providers submitting or causing to be submitted a claim using a facsimile, computer generated, typed or block letter signature shall bear full responsibility for submission of the claim as though the claim were personally signed by the provider or the provider's authorized agent.

(5) All medicaid claims submitted to the department by a hospital for services provided by a physician who is required to relinquish fees to the hospital are to be submitted on a state claim form which is:

(a) personally signed by the physician provider;

(b) personally signed by a person who has actual written authority to bind and represent the physician provider for this purpose. The department may require a provider to furnish this written authorization; or

(c) signed by the use of a facsimile signature stamp or a computer generated, typed or block letter signature. Providers submitting or causing to be submitted a claim using a facsimile, computer-generated, typed or block letter signature shall bear full responsibility for submission of the claim as though the claim were personally signed by the provider or the provider's authorized agent.

(6) The department may require a hospital provider to obtain on the claim form the signature of a physician providing services for which fees are relinquished to the hospital.

(7) Electronic media claims may be submitted by a provider who enters into an agreement with the department for this purpose and who meets the department's requirements for documentation, record retention and signature requirements.

(8) Claims submitted for the professional component of electrodiagnostic procedures which do not involve direct personal care on the part of the physician and performed by physicians on contract to the hospital may be submitted on state approved claim forms signed by the person with authority to bind the hospital under (5)(b).

(a) Electrodiagnostic procedures include echocardiology studies, electroencephalography studies, electrocardiology studies, evoked potential studies, holter monitors, telephonic or teletrace checks and pulmonary function tests.

(b) If, after review, the department determines that claims for hospital-based physician services are not submitted by a hospital provider in accordance with this rule, the department may require the hospital provider to obtain the signature of the physician providing the service on the claim form.

(9) If the department pays a claim but subsequently discovers that the provider was not entitled to payment for any reason, the department is entitled to recover the resulting overpayment as provided in (10).

(10) The department is entitled to recover from the provider and the provider is obligated to repay to the department all medicaid payments made to which the provider was not entitled under applicable state and federal laws, regulations and rules. At the option of the department, recoveries may be accomplished by a direct payment to the department or by automatic deductions from future payments due the provider. Notice of overpayment must be made in accordance with ARM 37.85.512.

(a) The department is entitled to recover under (10) any payment to which the provider was not entitled, regardless of whether the payment was the result of department or provider error, or other cause, and without proving that the provider submitted an improper or erroneous claim knowingly, intentionally, or with intent to defraud.

(b) The department is entitled to recover an overpayment from the provider in whose name the erroneous or improper claim was submitted, even if the provider was an employee of another individual or entity and was required as a condition of the provider's employment to turn over all fees received by the provider to the employer.

(11) Providers are required to accept, as payment in full, the amount paid by the Montana medicaid program for a service or item provided to an eligible medicaid recipient in accordance with the rules of the department. Providers shall not seek any payment in addition to or in lieu of the amount paid by the Montana medicaid program from a recipient or his representative, except as provided in these rules. A provider may bill a recipient for the copayments specified in ARM 37.83.826 and 37.85.204 and may bill certain recipients for amounts above the medicare deductibles and coinsurance as allowed in ARM 37.83.825.

(a) A provider may bill a recipient for noncovered services if the provider has informed the recipient in advance of providing the services that medicaid will not cover the services and that the recipient will be required to pay privately for the services, and if the recipient has agreed to pay privately for the services. For purposes of (11)(a), non-covered services are services that may not be reimbursed for the particular recipient by the Montana medicaid program under any circumstances and covered services are services that may be reimbursed by the Montana medicaid program for the particular recipient if all applicable requirements, including medical necessity, are met.

(b) Except as provided in this rule, a provider may not bill a recipient after medicaid has denied payment for covered services because the services are not medically necessary for the recipient.

(i) A provider may bill a recipient for covered but medically unnecessary services, including services for which medicaid has denied payment for lack of medical necessity, if the provider specifically informed the recipient in advance of providing the services that the services are not considered medically necessary under medicaid criteria, that medicaid will not pay for the services and that the recipient will be required to pay privately for the services, and the recipient has agreed to pay privately for the services. The agreement to pay privately must be based upon definite and specific information given by the provider to the recipient indicating that the service will not be paid by medicaid. The provider may not bill the recipient under this exception when the provider has informed the recipient only that medicaid may not pay or where the agreement is contained in a form that the provider routinely requires recipients to sign.

(ii) An ambulance service provider may bill a recipient after medicaid has denied payment for lack of medical necessity.

(c) A provider may not bill a recipient for services as a private pay patient if, prior to provision of the services, the recipient informed the provider of medicaid eligibility, unless, prior to provision of the services, the provider informed the recipient of its refusal to accept medicaid and the recipient agreed to pay privately for the services.

(d) In service settings where the recipient is admitted or accepted as a medicaid recipient by a provider, facility, institution or other entity that arranges provision of services by other or ancillary providers, all other or ancillary providers will be deemed to have accepted the individual as a medicaid recipient and may not bill the recipient for the services unless, prior to provision of services, the particular provider informed the recipient of its refusal to accept medicaid and the recipient agreed to pay privately for the services.

(e) The provider may not bill a recipient for services when medicaid does not pay as a result of the provider's failure to comply with applicable enrollment, prior authorization, billing or other requirements necessary to obtain payment.

(f) Acceptance of a recipient as a medicaid recipient applies to all services provided by the provider to the recipient, except as provided in (11)(a) or (b). A provider may not accept medicaid payment for some covered services but refuse to accept medicaid for other covered services. Subject to the requirements of ARM 37.85.402(4), a provider may terminate acceptance of medicaid for a recipient in accordance with the provider's professional responsibility, by informing the recipient of the termination and the effect of the termination on provision of and payment for any further services.

(g) If an individual has agreed prior to receipt of services that payment will be made from a source other than medicaid but later is determined retroactively eligible for medicaid, the provider may choose to accept the individual as a medicaid recipient with respect to the services or to seek payment in accordance with the original payment agreement.

(h) A provider that bills medicaid for services rendered will be deemed to have accepted the individual as a medicaid recipient.

(i) Nothing in this rule is intended to permit a provider to refuse to accept an individual as a medicaid recipient where the provider is otherwise required by law to accept an individual as a medicaid recipient.

(12) In the event that a provider of services is entitled to a retroactive increase of payment for services rendered, the provider shall submit a claim within 180 days of the written notification of the retroactive increase or the provider forfeits any rights to the retroactive increase.

(13) The Montana medicaid program shall make payments directly to the individual provider of service unless the individual provider is required, as a condition of his employment, to turn his fees over to his employer.

(a) Exceptions to the above requirement may, at the discretion of the department, be made for transportation and/or per diem costs incurred to enable a recipient to obtain medically appropriate services.

(14) The method of determining payment rates for out-of-state providers will be the same as for in-state providers except as otherwise provided in the rules of the department.

(15) A government agency may bill the medicaid program for covered medical services under the following circumstances:

(a) The government agency has complied with all federal and state law governing the medicaid program, and assures that the provider has complied with all state and federal law governing the medicaid program, including reimbursement levels.

(b) The government agency accepts assignment from an eligible medicaid provider for services provided prior to eligibility determination.

(16) A person enrolled as an individual provider may not submit a claim for services that the provider did not personally provide, inclusive of services provided by another person under the provider's supervision, unless authorization to bill for and receive reimbursement for services the provider did not personally provide is stated in administrative rule or a Montana medicaid program manual and is in compliance with any supervision requirements in state law or rule governing the provider's professional practice and the practice of assistants and aides. Other providers, including but not limited to hospitals, nursing facilities and home health agencies, may bill for and receive reimbursement for services provided by supervised persons in accordance with the medicaid rules and manual and any supervision requirements in state law or rule governing professional practice.

(17) Medicaid coverage and reimbursement is available only for services or items that are provided in accordance with all applicable medicaid requirements and within the scope of practice permitted under state licensure laws and other mandatory standards applicable to the provider.

(18) Except as otherwise provided in the rules of the department which pertain to the method of determining payment rates for claims of recipients who have medicare and medicaid coverage (cross-over claims), the medicaid allowed amount for medicare covered services is:

(a) for facility based providers who generally bill on the UB-92 billing form, for covered medical services the full medicare co-insurance and deductible as defined by the medicare carrier;

(i) there is an exception for inpatient ancillary services with medicare Part B coverage only (no medicare Part A) or FQHCs: medicare payments for these services are treated as third party payments and are offset against the medicaid payment;

(b) for medical providers who generally bill on the HCFA-1500 billing form, for covered medical services the lower of:

(i) the medicare co-insurance and deductible (if not met); or

(ii) the medicaid fee less the amount paid by medicare for the same service, not to exceed the medicaid fee for that service;

(c) for mental health services that are subject to the medicare psychiatric reduction, the lower of:

(i) the medicaid allowed amount; or

(ii) the medicare allowed amount, less the medicare paid amount;

(d) for services to recipients eligible to receive both medicare and medicaid benefits, an amount not to exceed the medicare allowed amount in instances where the medicaid fee is higher than the medicare allowable.

(19) For all purposes of this rule, the amount of the provider's usual and customary charge may not exceed the reasonable charge usually and customarily charged to all payers.

(20) Reimbursement from medicaid may not exceed an amount which would cause total payment to the provider from both medicaid and all other payers to exceed the medicaid fee.

(21) There is an emergency reimbursement reduction in effect for the following provider types for services provided January 10, 2003 through June 30, 2003:

(a) inpatient hospital;
(b) outpatient hospital;
(c) early periodic screening;
(d) diagnostic and treatment;
(e) nutritional services;
(f) chiropractic;
(g) podiatry;
(h) physical therapy;
(i) speech-language pathology;
(j) occupational therapy;
(k) audiology;
(l) optometry;
(m) public health clinic;
(n) dental;
(o) prosthetic devices;

(p) durable medical equipment and supplies;
(q) non-emergency transportation;
(r) ambulance;
(s) physician;
(t) ambulatory surgical center;
(u) non-hospital lab and x-ray;
(v) denturist;
(w) mid-level practitioner;
(x) qualified medicare beneficiary (QMB) services;
(y) QMB chiropractic; and
(z) freestanding dialysis clinics.

(22) The net pay reimbursement for the provider types listed in (21) is 7% less than the amount provided in the following rules: ARM 37.83.811, 37.83.812, 37.83.825, 37.85.212, 37.86.105, 37.86.205, 37.86.506, 37.86.610, 37.86.705, 37.86.1004, 37.86.1005, 37.86.1406, 37.86.1806, 37.86.1807, 37.86.2005, 37.86.2207, 37.86.2209, 37.86.2211, 37.86.2405, 37.86.2505, 37.86.2605, 37.86.2801, 37.86.2904, 37.86.2905, 37.86.2907, 37.86.2912, 37.86.2914, 37.86.2916, 37.86.2918, 37.86.2920, 37.86.2924, 37.86.2925, 37.86.3005, 37.86.3006, 37.86.3007, 37.86.3009, 37.86.3011, 37.86.3014, 37.86.3016, 37.86.3018, 37.86.3020, 37.86.3022, 37.86.3205 and 37.86.4205.

(a) For purposes of this rule, "net pay reimbursement" means the allowed amount minus third party liability payments, copayments, coinsurance, incurments, and other deductions.

(23) Notwithstanding any other provision, critical access hospital interim reimbursement is based on hospital specific medicaid cost to change ratio. Critical access hospitals will still be reimbursed their actual allowable costs determined on a retrospective basis as provided in ARM 37.86.2803. (History: Sec. 53-2-201 and 53-6-113, MCA; IMP, Sec. 53-2-201, 53-6-101, 53-6-111, 53-6-113, 53-6-131 and 53-6-141, MCA; NEW, 1980 MAR p. 1491, Eff. 5/16/80; AMD, 1981 MAR p. 530, Eff. 5/29/81; AMD, 1981 MAR p. 559, Eff. 6/12/81; AMD, 1981 MAR p. 771, Eff. 7/31/81; AMD, 1983 MAR p. 1197, Eff. 8/26/83; AMD, 1986 MAR p. 359, Eff. 3/14/86; AMD, 1987 MAR p. 894, Eff. 6/26/87; AMD, 1989 MAR p. 835, Eff. 6/30/89; AMD, 1990 MAR p. 379, Eff. 2/23/90; AMD, 1990 MAR p. 1586, Eff. 8/17/90; AMD, 1992 MAR p. 234, Eff. 2/14/92; AMD, 1997 MAR p. 474, Eff. 3/11/97; AMD, 1998 MAR p. 676, Eff. 3/13/98; AMD, 1998 MAR p. 2168, Eff. 8/14/98; TRANS, from SRS, 2000 MAR p. 479; AMD, 2001 MAR p. 1476, Eff. 8/10/01; AMD, 2001 MAR p. 2156, Eff. 10/26/01; EMERG, AMD, 2002 MAR p. 797, Eff. 3/15/02; EMERG, AMD, 2003 MAR p. 999, Eff. 5/9/03; AMD, 2003 MAR p. 1652, Eff. 8/1/03; AMD, 2004 MAR p. 482, Eff. 2/27/04.)

37.85.407 THIRD PARTY LIABILITY (1) No payment shall be made by the department for any medical service for which there is a known third party who has a legal liability to pay for that medical service except for those services specified in (6) below.

(2) For purposes of this section, the following definitions apply:

(a) A third party is defined as an individual, institution, corporation, or public or private agency that is or may be liable to pay all or part of the cost of medical treatment and medical-related services for personal injury, disease, illness, or disability of a recipient of medical assistance from the department or a county and includes but is not limited to insurers, health service organizations, and parties liable or who may be liable in tort. Indian health services is not a third party within the meaning of this definition.

(b) A known third party is a third party for which the provider has sufficient information to submit a claim and which if billed for a medical service is likely to pay the claim within a reasonable time.

(c) A potential third party is a third party for which the provider either has insufficient information to submit a claim or which if billed for a medical service, is likely to deny the claim as having no contractual or legal obligation to pay.

(3) For known recipients, the provider shall use its same usual and customary procedures for inquiring about possible third party resources as is done for non-recipients.

(4) If the provider delivers to a recipient or a recipient's legal representative a copy of a billing statement for services which have been or may be billed to the department, the statement must clearly indicate that third party benefits or payments have been assigned to the department by the patient or that the department may have a lien upon such benefits.

(a) The words "medicaid has assignment of, or may have a lien upon third party benefits or payments" shall be sufficient to meet the notification requirement of this section.

(b) If a provider does not meet the notification requirements of this section, the department may withhold or recover from the provider an amount equal to any amounts paid by a third party towards the services described in the statement given to the recipient.

(5) If a provider learns of the existence of a known third party, that provider shall bill the third party prior to billing the department. If the department has knowledge of a known third party and the provider has not complied with (6) or (7) below, the department shall deny payment of the services.

(6) The department shall not deny payment of services solely because of the existence of a third party in the following circumstances:

(a) The primary diagnosis on the claim is for certain prenatal and preventive pediatric care as specified in the medicaid provider manual, copies of which may be obtained from the Montana Department of Public Health and Human Services, Health Policy and Services Division, 1400 Broadway, P.O. Box 202951, Helena, MT 59620-2951. The provider may bill the third party or the department in this circumstance.

(b) The third party is an insurer under a health insurance policy provided by the absent parent of a recipient and that health insurance is obtained or maintained as a result of an enforcement action taken by the child support enforcement division against that absent parent, if the following provisions are met:

(i) the provider submits evidence that the third party has been billed;

(ii) the claim is submitted to the department 30 or more days beyond the date of service and in compliance with the timely filing rules in ARM 37.85.406(1);

(iii) the provider certifies on the claim that notice of payment or denial of the claim has not been received from the third party; and

(iv) the claim is submitted directly to the third party liability unit (hereafter referred to as the TPL unit) within the department.

(c) The provider has billed the third party and has not received a reply from the third party either allowing or denying payment, if the following provisions are met:

(i) the provider submits evidence of the date the third party was billed;

(ii) the claim is submitted 90 or more days beyond the date established in (c)(i) and in compliance with the timely filing rules in ARM 37.85.406(1);

(iii) the provider certifies on the claim that notice of payment or denial has not been received; and

(iv) the provider submits the claim directly to the TPL unit.

(d) The claim is for services for which the department has been granted a waiver from use of the cost avoidance method and the department has chosen to use and continue to use that waiver, as identified in the medicaid provider manual.

(e) The provider is unable to obtain a valid assignment of benefits, if the following provisions are met:

(i) the provider submits documentation that it attempted to obtain assignment;

(ii) the provider certifies on the claim that assignment could not be obtained; and

(iii) the provider submits the claim directly to the TPL unit.

(f) The third party is only a potential third party as defined in (2)(c).

(7) Except as stated in (8), the department shall pay its allowed amount for services, less any known third party payments for those services, for any claim where a known third party exists in the following circumstances:

(a) the claim is submitted under the provisions of (6);

(b) the submitted claim clearly indicates the amount paid by the third party and includes whatever documentation is received regarding the payment from the third party; or

(c) the claim is submitted with a denial document which clearly shows that the third party denied the claim.

(8) For inpatient hospital claims where medicare Part A benefits have been paid, the department's sole obligation shall be to pay the medicare Part A deductible. For nursing facility service claims where medicare Part A benefits have been paid, the department's sole obligation shall be to pay in accordance with ARM 37.40.307.

(9) In the event the provider receives a payment from a third party after the department has made payment, the provider shall refund to the department, within 60 days of receipt of the third party payment, the lesser of the amount the department paid or the amount of the third party payment.

(a) The refund shall be made payable to Montana medicaid and submitted to the department's fiscal office, and shall indicate the name of the third party payor.

(b) The provider is entitled to retain any third party payments which exceed the medicaid allowed amount if all medicaid payments toward those services have been refunded to the department as required in this subsection.

(10) The department shall make no payment for services in those cases where, if the patient were not a medicaid recipient, the third party payment would constitute full payment with no further obligation owing from the recipient.

(11) For any service where an identified third party has only a potential liability as a tort-feasor, the provider may file a medical lien against that third party. The provider may bill the department prior to determination of liability of the third party if the provider notifies the TPL unit of the identity of the third party and its name and address if known. The provider may keep its lien in place and receive payment from the third party. If payment is received from the third party, the provider must refund to the department as described in (9).

(12) A provider may not refuse to furnish services to a recipient based upon a third party's potential liability for the service. (History: Sec. 53-6-113, MCA; IMP, Sec. 53-2-201, 53-6-101, 53-6-111, 53-6-113 and 53-6-141, MCA; NEW, 1980 MAR p. 1491, Eff. 5/16/80; AMD, 1984 MAR p. 1637, Eff. 11/16/84; AMD, 1990 MAR p. 1719, Eff. 8/31/90; AMD, 1997 MAR p. 474, Eff. 3/11/97; TRANS, from SRS, 2000 MAR p. 479.)

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37.85.410 DETERMINATION OF MEDICAL NECESSITY (1) The department shall only make payment for those services which are medically necessary as determined by the department or by the designated review organization.

(2) In determining medical necessity the department or designated review organization may consider the type or nature of the service, the provider of the service, the setting in which the service is provided and any additional requirements applicable to the specific service or category of service.

(3) The department may review the medical necessity of services or items at any time either before or after payment. If the department determines that services or items were not medically necessary or otherwise in compliance with applicable requirements, the department may deny payment or may recover any overpayment in accordance with applicable requirements. The department is not precluded by an earlier screening, prior authorization, certification or similar process from reviewing and determining medical necessity of any service or item, or from denying payment or recovering any overpayment based upon any such review or determination. This rule does not require the department to notify a provider or recipient of a medical necessity determination until and unless the department completes its review and takes an adverse action against the provider based upon the determination.

(4) The provider must upon request provide to the department or its designated review organization without charge any records related to services or items provided to a recipient. (History: Sec. 53-2-201 and 53-6-113, MCA; IMP, Sec. 53-2-201, 53-6-101, 53-6-111, 53-6-113 and 53-6-141, MCA; NEW, 1980 MAR p. 1491, Eff. 5/16/80; AMD, 1997 MAR p. 474, Eff. 3/11/97; TRANS, from SRS, 2000 MAR p. 479.)

37.85.411 PROVIDER RIGHTS (1) Except as otherwise provided in these rules, a provider who is aggrieved by an adverse department action which directly affects the rights or entitlements of the provider under the Montana medicaid program, may request a hearing to the extent provided and according to the procedures specified in ARM 37.5.304, 37.5.305, 37.5.307, 37.5.310, 37.5.311, 37.5.313, 37.5.316, 37.5.322, 37.5.325, 37.5.328, 37.5.331, 37.5.334 and 37.5.337.

(2) Except as otherwise provided in these rules, a provider who is aggrieved by an adverse department action affecting the applicant's or recipient's eligibility under the Montana medicaid program, may request a hearing to the extent provided and according to the procedures specified in ARM 37.5.304, 37.5.305, 37.5.307, 37.5.310, 37.5.311, 37.5.313, 37.5.316, 37.5.322, 37.5.325, 37.5.328, 37.5.331, 37.5.334 and 37.5.337.

(3) This rule does not grant to providers any right to notice of actions affecting recipients, including but not limited to eligibility determinations. (History: Sec. 2-4-201 and 53-6-113, MCA; IMP, Sec. 2-4-201, 53-2-201, 53-6-101, 53-6-111, 53-6-113 and 53-6-141, MCA; NEW, 1980 MAR p. 1491, Eff. 5/16/80; AMD, 1997 MAR p. 474, Eff. 3/11/97; TRANS & AMD, from SRS, 2000 MAR p. 1653, Eff. 6/30/00.)

37.85.412 INTERPRETATION OF RULES (1) The department will interpret its rules by giving meaning to the plain language of the rules. If a provider requests an interpretation of a rule to provide clarification of a perceived ambiguity, clarification must be received in writing from the department before the service is billed to medicaid, or the provider may not rely on it.

(2) Documentation of the clarification must contain:

(a) the date of the response;

(b) the identity of the person providing the clarification; and

(c) the specifics of the text of the provider's inquiry. (History: Sec. 53-6-113, MCA; IMP, Sec. 53-6-101, MCA; NEW, 2005 MAR p. 459, Eff. 4/1/05.)

37.85.413 LIMITATIONS ON CODING ADVICE (1) Employees of the department, or of any contractor or agent of the department, may give a provider general information as to what codes are available for billing under medicaid for a particular service or item being provided. However, the provider retains responsibility for selecting and submitting the proper code to describe the service or item provided. If an employee of the department or of a contractor or agent of the department suggests, recommends, or directs the provider to use a particular code from the choices available or gives other specific coding advice, the provider may not rely on such advice unless the advice is provided in writing before the provider submits a claim for the service or item. (History: Sec. 53-6-113, MCA; IMP, Sec. 53-6-101, MCA; NEW, 2005 MAR p. 459, Eff. 4/1/05.)

37.85.414 MAINTENANCE OF RECORDS AND AUDITING (1) All providers of service must maintain records which fully demonstrate the extent, nature and medical necessity of services and items provided to Montana medicaid recipients. The records must support the fee charged or payment sought for the services and items and demonstrate compliance with all applicable requirements.

(a) All records which support a claim for a service or item must be complete within 90 days after the date on which the claim was submitted to medicaid for reimbursement. A record that is required to be signed and dated, including but not limited to an order, prescription, certificate of medical necessity, referral or progress note, is not complete until it has been signed and dated.

(b) When reimbursement is based on the length of time spent in providing the service, the records must specify the time spent or the time treatment began and ended for each procedure billed to the nearest minute. Total time billed using one or multiple procedure codes may not exceed the total actual time spent with the medicaid client.

(c) These records must be retained for a period of at least six years and three months from the date on which the service was rendered or until any dispute or litigation concerning the services is resolved, whichever is later.

(d) In maintaining financial records, providers shall employ generally accepted accounting methods. Generally accepted accounting methods are those approved by the national association of certified public accountants.

(e) The department shall have access to all records so maintained and retained regardless of a provider's continued participation in the program.

(f) In the event of a change of ownership, the original owner must retain all required records unless an alternative method of providing for the retention of records has been established in writing and approved by the department.

(g) If a provider cannot provide medical records to prove that a service billed to medicaid was provided and meets all requirements for reimbursement, the service will be deemed not to be provided and reimbursable due to the lack of documentation, and the department will recover all reimbursement paid to the provider. This recovery is permissible regardless of whether the documentation was destroyed or lost due to an event such as, but not limited to, misplaced records, a data processing failure, fire, earthquake, flood, or other natural disaster. The provider must have a backup system in place to allow recovery of documentation destroyed or lost due to such events or any other cause.

(h) These record keeping requirements are the minimum requirements for records to support all medicaid claims. In addition to complying with these minimum requirements, providers must also comply with any specific record keeping requirements applicable to the type of service the provider furnishes, which may be more restrictive than the minimum requirements of this rule.

(2) In addition to the recipient's medical records, any medicaid information regarding a recipient or applicant is confidential and shall be used solely for purposes related to the administration of the Montana medicaid program. This information shall not be divulged by the provider or his employees, to any person, group, or organization other than those listed below or a department representative without the written consent of the recipient or applicant. In addition, the provider must comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 42 USC 1320d et seq., and the Uniform Health Care Information Act, 50-16-501 et seq., MCA.

(3) The department, the designated review organization, the legislative auditor, the department of revenue, the medicaid fraud control unit, and their legal representatives shall have the right to inspect or evaluate the quality, appropriateness, and timeliness of services performed by providers, and to inspect and audit all records required by this rule.

(a) Upon the department's request for records, the provider shall submit a true and accurate copy of each record of the service or item being reviewed as it existed within 90 days after the date on which the claim was submitted to medicaid.

(b) Refusal to permit inspection, evaluation or audit of services shall result in the imposition of provider sanctions in accordance with the rules of the department.

(4) The provisions of this rule specifying the length of time for which records must be retained shall not be construed as a limitation on the period in which the department may recover overpayments or impose sanctions. (History: Sec. 53-6-113, MCA; IMP, Sec. 53-2-201, 53-6-101, 53-6-111, 53-6-113 and 53-6-141, MCA; NEW, 1980 MAR p. 1491, Eff. 5/16/80; AMD, 1997 MAR p. 474, Eff. 3/11/97; TRANS, from SRS, 2000 MAR p. 479; AMD, 2005 MAR p. 459, Eff. 4/1/05.)

37.85.415 MEDICAL ASSISTANCE MEDICAID PAYMENT

(1) Medicaid will pay only for medical expenses:

(a) incurred by a person eligible for the medicaid program;

(b) for services provided for and to the extent provided for under the medicaid program;

(c) for which third party payment is not available;

(d) not used to meet the incurrment requirement at ARM 37.82.1101 and following rules for persons who are medically needy;

(e) which are not the cost sharing provided for in ARM 37.85.204; and

(f) to the extent allowed by medicaid. (History: Sec. 53-2-201 and 53-6-113, MCA; IMP, Sec. 53-6-101 and 53-6-131, MCA; NEW, 1989 MAR p. 835, Eff. 6/30/89; TRANS, from SRS, 2000 MAR p. 479; AMD, 2002 MAR p. 797, Eff. 3/15/02.)

37.85.416 STATISTICAL SAMPLING AUDITS (1) At the option of the department, the amount of money erroneously paid to a provider for any given period of time may be determined by the use of statistical sampling and extrapolation, rather than by an audit of 100% of the claims submitted by the provider during the period of time under review. Statistical sampling and extrapolation shall not be used to determine overpayments for inpatient hospital services, outpatient hospital services, or hospital inpatient psychiatric services, or in cases where the number of line items in the review period does not equal 500 or more.

(a) A line item consists of a single service, under one procedure rate with one or more units of service, procedure or item on a medicaid claim form for which a provider has received payment.

(2) If the department chooses to use statistical sampling and extrapolation to determine an overpayment, it will use a statistical method to draw a random sample of claims for the review period and will audit these claims. The department will calculate the provider's error rate based on the net dollar amount overpaid to the provider after any underpayments occurring in the sample have been offset against the overpayments occurring in the sample. The department will then calculate the total overpayment for the review period using an appropriate statistical methodology.

(3) If the department chooses to use statistical sampling and extrapolation, it shall notify the provider of its intention to do so. When the sampling and extrapolation process is completed, the department shall provide the provider with information regarding the sample size, the sample selection method, and the formulas and calculations used in the extrapolation.

(4) It is presumed that the overpayment amount determined by the use of statistical sampling and extrapolation is correct. However, the provider may rebut this presumption by presenting evidence that the sampling and extrapolation process used by the department was invalid, by presenting evidence that claims in the sample determined by the department to be erroneous or overpaid were correctly paid, or by requesting an audit of 100% of the claims paid in the review period, as provided in (5).

(5) A provider who does not agree with the overpayment amount determined by statistical sampling may request that the department conduct a 100% audit of the claims paid in the review period. The request for a 100% audit must be made within 30 days of the date of the notice informing the provider of the results of the statistical sampling. The department must then conduct such a review.

(a) If the audit shows an overpayment amount which is different from the overpayment amount determined by sampling and extrapolation, the amount determined by the audit shall be used by the department in assessing an overpayment against the provider. A provider who is aggrieved by a department determination based upon the results of the audit may appeal by means of the fair hearing procedures set forth in ARM 37.5.304, 37.5.305, 37.5.307, 37.5.310, 37.5.311, 37.5.313, 37.5.316, 37.5.322, 37.5.325, 37.5.328, 37.5.331, 37.5.334 and 37.5.337.

(b) The provider must pay the department's costs for such an audit, unless the overpayment amount determined by the 100% audit is at least 10% less than the overpayment amount determined by the statistical sample.

(6) A provider who is aggrieved by an overpayment determined by statistical sampling and extrapolation may appeal by means of the fair hearing procedures set forth in ARM 37.5.304, 37.5.305, 37.5.307, 37.5.310, 37.5.311, 37.5.313, 37.5.316, 37.5.322, 37.5.325, 37.5.328, 37.5.331, 37.5.334 and 37.5.337. (History: Sec. 53-6-113, MCA; IMP, Sec. 53-6-101 and 53-6-111, MCA; NEW, 1993 MAR p. 441, Eff. 3/26/93; TRANS & AMD, from SRS, 2000 MAR p. 1653, Eff. 6/30/00.)

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Subchapter 5

Provider Sanctions

37.85.501 GROUNDS FOR SANCTIONING (1) Sanctions may be imposed by the department against a provider of medical assistance, provided under ARM Title 37, chapters 40, 80, 82, 83, 85, 86, 88, for any one or more of the following reasons:

(a) Presenting or causing to be presented for payment any false or fraudulent claim for services or merchandise.

(b) Submitting or causing to be submitted false information for the purpose of obtaining greater compensation than that to which the provider is legally entitled under the rules of the department.

(c) Submitting or causing to be submitted false information for the purpose of meeting prior authorization requirements.

(d) Failure to maintain and retain records required by the rules of the department.

(e) Failure to disclose or make available required records to the department, its authorized agent or other legally authorized persons, organizations, or governmental entities.

(f) Failure to provide and maintain services to medicaid recipients at a quality that is within accepted medical community standards as adjudged by a body of peers.

(g) Engaging in a course of conduct or performing an act which the department's rules or the decision of the applicable professional peer review committee, or licensing board, have determined to be improper or abusive of the Montana medicaid program; or continuing such conduct following notification that the conduct should cease.

(h) Breach of the terms of the provider contract or failure to comply with the terms of the provider certification on medical assistance claim forms or the failure to comply with requirements imposed by the rules of the department.

(i) Over-utilizing the Montana medicaid program by inducing, or otherwise causing a recipient to receive services or goods not medically necessary.

(j) Rebating or accepting a fee or portion of a fee or charge for a medicaid patient referral.

(k) Violating any provision of the state medicaid law, Title 53, chapter 6, MCA or any rule promulgated pursuant thereto, or violating any provision of Title XIX of the Social Security Act or any regulation promulgated pursuant thereto.

(l) Submission of a false or fraudulent application for provider status.

(m) Violations of any statutes, regulations or code of ethics governing the conduct of occupations or professions or regulated industries.

(n) Conviction of a criminal offense relating to medical assistance programs administered by the department or provided under contract with the state; or conviction for negligent practice resulting in death or injury to patients.

(o) Failure to meet requirements of state or federal law for participation (e.g. licensure).

(p) Exclusion from the medicare program (Title XVIII of the Social Security Act) because of fraudulent or abusive practices.

(q) Charging medicaid recipients for amounts over and above the amounts paid by the department for services rendered, except as specifically allowed under ARM 37.83.825 and 37.83.826.

(r) Refusal to execute a new provider agreement when requested to do so.

(s) Failure to correct deficiencies as defined by the ARM or federal regulation after receiving written notice of these deficiencies from the department, or the federal department of health and human services. The standards set forth at 42 CFR Part 442, Part 483 and Part 488, updated through February 2004, which identify deficiencies for providers of intermediate care facilities for the mentally retarded, skilled nursing and nursing facility services, are incorporated by reference. A copy of 42 CFR Part 442, Part 483 and Part 488, updated through February 2004, are available from the Department of Public Health and Human Services, Quality Assurance Division, 2401 Colonial Drive, P.O. Box 202653, Helena, MT 59620-2953.

(t) Formal reprimand or censure by an association of the provider's peers for unethical practices.

(u) Suspension or termination from participation in another government medical program including but not limited to workers' compensation, crippled children's services, rehabilitation services and medicare.

(v) Filing of criminal indictment, information or complaint for fraudulent billing practices or negligent practice resulting in death or injury to the provider's patients.

(w) Civil judgement for fraudulent billing practices or negligent practice resulting in death or injury to the provider's patients.

(x) Failure to repay or make acceptable arrangements for the repayment of identified overpayments or otherwise erroneous payments.

(y) Threatening, intimidating or harassing patients or their relatives in an attempt to influence reimbursement rates or affect the outcome of disputes between the provider and the department.

(z) Submitting claims for reimbursement of costs or services which the provider knows or has reason to know are not reimbursable. (History: Sec. 53-2-201, 53-2-803, 53-4-111, 53-6-111 and 53-6-113, MCA; IMP, Sec. 53-2-306, 53-2-801, 53-2-803, 53-4-112, 53-6-111 and 53-6-131, MCA; NEW, 1980 MAR p. 1619, Eff. 6/13/80; AMD, 1984 MAR p. 1639, Eff. 11/16/84; AMD, 1986 MAR p. 1321, Eff. 8/1/86; AMD, 1987 MAR p. 2164, Eff. 11/28/87; AMD, 1989 MAR p. 835, Eff. 6/30/89; TRANS, from SRS, 2000 MAR p. 479; AMD, 2004 MAR p. 736, Eff. 4/9/04.)

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37.85.502 SANCTIONS (1) The following sanctions may be invoked against providers based on the grounds specified in ARM 37.85.501:

(a) Termination from participation in the medical assistance program.

(b) Suspension of participation in the medical assistance program.

(c) Suspension or withholding of payments to a provider.

(d) Shortening of an existing provider agreement as permitted by the terms of such agreement.

(e) Required attendance at provider education sessions, the cost of which shall not be reimbursed by the department or any of its programs.

(f) Required prior authorization for provision of services.

(g) 100% review of the provider's claims prior to payment.

(h) Referral to the department of revenue for any action deemed necessary.

(i) In addition to the sanctions listed above, intermediate care facilities for the mentally retarded, skilled nursing and nursing facilities shall be subject to termination of participation when the deficiencies resulting from failure to meet conditions or standards of participation pose immediate jeopardy or the denial of payments for new admissions if the facility's deficiencies resulting from failure to meet conditions or standards of participation do not pose immediate jeopardy. Federal laws regarding termination from participation and intermediate sanctions provided in 42 CFR 442.2, 42 CFR 442.117 through 442.119, and 42 CFR Part 483 and 488, updated through February 2004 are incorporated by reference. A copy of 42 CFR 442.2, 42 CFR 442.117 through 442.119, and 42 CFR Part 483 and 488, updated through February 2004 may be obtained from the Department of Public Health and Human Services, Quality Assurance Division, 2401 Colonial Drive, Helena, MT 59620-2953; or

(j) Notification to the public of sanctions taken against a provider. (History: Sec. 53-2-201, 53-2-803, 53-4-111, 53-6-108, 53-6-111 and 53-6-113, MCA; IMP, Sec. 53-2-306, 53-2-801, 53-4-112, 53-6-106, 53-6-107 and 53-6-111, MCA; NEW, 1980 MAR p. 1619, Eff. 6/13/80; AMD, 1984 MAR p. 1639, Eff. 11/16/84; AMD, 1987 MAR p. 2164, Eff. 11/28/87; TRANS, from SRS, 2000 MAR p. 479; AMD, 2004 MAR p. 736, Eff. 4/9/04.)

Rules 03 and 04 reserved

37.85.505 FACTORS GOVERNING IMPOSITION OF SANCTION

(1) The decision to impose sanctions and which sanctions to impose shall be within the discretion of the department except as provided in (3).

(2) The following factors shall be considered in determining the sanction(s) to be imposed:

(a) seriousness of the offense(s);

(b) extent of violations;

(c) history of prior violations;

(d) prior imposition of sanctions;

(e) prior provision of provider education;

(f) provider willingness to comply with program rules;

(g) whether a lesser sanction will be sufficient to remedy the problem;

(h) actions taken or recommended by peer review groups or licensing boards.

(3) Where a provider has been found by a court of competent jurisdiction in either a civil or criminal proceeding to have defrauded the Montana medical assistance program, or has been previously suspended due to program abuse, or has been terminated from the medicare program for fraud or abuse, the department may terminate the provider from the medical assistance program. (History: Sec. 53-2-201, 53-2-803, 53-4-111, 53-6-108, 53-6-111 and 53-6-113, MCA; IMP, Sec. 53-2-306, 53-2-801, 53-4-112, 53-6-106, 53-6-107 and 53-6-111, MCA; NEW, 1980 MAR p. 1619, Eff. 6/13/80; AMD, 1984 MAR p. 1639, Eff. 11/16/84; TRANS, from SRS, 2000 MAR p. 479.)

37.85.506 SCOPE OF SANCTION (1) A sanction may be applied to all known affiliates of a provider, provided that each decision to include an affiliate is made on a case by case basis after giving due consideration to all relevant facts and circumstances. The violation, failure, or inadequacy of performance may be imputed to an affiliate where such conduct was accomplished within the course of the affiliate's official duty or was effectuated by the provider with the knowledge or approval of the affiliate.

(2) Suspension or termination from participation of any provider shall preclude such provider from submitting claims for payment, either personally or through claims submitted by any clinic, group, corporation or other association to the department or its fiscal agents for any services or supplies provided to persons eligible for the Montana medical assistance program except for those services or supplies provided prior to the suspension or termination. Providers of long term care facility services may submit claims for supplies and services provided for up to 30 days after the date of termination to allow for the transfer of recipients.

(3) No clinic, group, corporation or other association which is a provider of services shall submit claims for payment to the department or its fiscal agents for any services or supplies provided by a person within such organization who has been suspended or terminated from participation in the Montana medical assistance program except for those services or supplies provided prior to the suspension or termination. Providers of long term care facility services may submit claims for supplies and services provided for up to 30 days after the date of termination to allow for the transfer of recipients.

(4) When the provisions of (3) of this rule are violated by a provider of services which is a clinic, group, corporation, the department may suspend or terminate such organization and/or any individual person within said organization who is responsible for such violation. (History: Sec. 53-2-201, 53-2-803, 53-4-111, 53-6-111 and 53-6-113, MCA; IMP, Sec. 53-2-306, 53-2-801, 53-4-112 and 53-6-111, MCA; NEW, 1980 MAR p. 1619, Eff. 6/13/80; AMD, 1984 MAR p. 1639, Eff. 11/16/84; AMD, 1987 MAR p. 2164, Eff. 11/28/87; TRANS, from SRS, 2000 MAR p. 479.)

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37.85.507 NOTICE OF SANCTION (1) When a provider has been suspended or terminated, the department shall notify the appropriate professional society, board of registration or licensure, and federal or state agencies of the findings made and the sanctions imposed. (History: Sec. 53-6-111, MCA; IMP, Sec. 53-6-111, MCA; NEW, 1980 MAR p. 1619, Eff. 6/13/80; TRANS, from SRS, 2000 MAR p. 479.)

Rules 08 through 10 reserved

37.85.511 PROVIDER EDUCATION (1) Except where termination has been imposed, the department may in its discretion direct each provider, who has been sanctioned, to participate in a provider education program as a condition of continued medicaid participation.

(2) Provider education programs may include any of the following at the discretion of the department:

(a) instruction in claim form completion;

(b) instruction on the use and format of provider manuals;

(c) instruction on the use of procedure codes;

(d) instruction on statutes and regulations governing the Montana medicaid program;

(e) instruction on reimbursement rates;

(f) instructions on how to inquire about coding or billing problems;

(g) any other matter as determined by the department. (History: Sec. 53-6-111, MCA; IMP, Sec. 53-6-111, MCA; NEW, 1980 MAR p. 1619, Eff. 6/13/80; TRANS, from SRS, 2000 MAR p. 479.)

37.85.512 NOTICE OF ADVERSE ACTION (1) As provided in this rule, the department must notify a provider of any adverse action it will take on a determination that the provider has engaged in fraud or abuse or has received payment to which the provider is not entitled. The notification must include:

(a) a description of the fraud, abuse or overpayments;

(b) the dollar value of any overpayment; and

(c) the adverse action to be taken or sanction to be imposed by the department;

(d) explanation of any actions required of the provider;

(e) the provider's right to a fair hearing.

(2) The department is not required to notify a provider pursuant to (1) until after the department has determined that fraud, abuse or an overpayment has occurred, the dollar amount of any overpayment and that a particular adverse action will be taken by the department against the provider, such as recovery of an overpayment or imposition of a sanction. The department is not required to notify the provider when the department merely suspects or has information which suggests that fraud, abuse or an overpayment has occurred or when the department has not determined to take a particular adverse action in response to the fraud, abuse or overpayment.

(3) Subject to the provisions of (4), the department must notify the provider as required in this rule within 45 days after the department has determined that fraud, abuse or an overpayment has occurred, the dollar amount of any overpayment and the adverse action that will be taken against the provider. The department's failure to notify a provider as required by this rule is not a defense to recovery of the overpayment or imposition of the sanction, but the department may be required to provide a new notice in compliance with this rule.

(4) This rule shall not be construed to require that the department investigate, complete an investigation, make a determination or take any other action regarding a potential fraud, abuse or overpayment within any particular time.

(5) While this rule does not require the department to act within any particular time, if any governmental agency or entity is conducting an investigation of a provider, the department shall not in any event be required to notify the provider of a violation or overpayment until the investigation is concluded and enforcement proceedings, if any, have been completed, if in the sole discretion of the department or the governmental agency or entity conducting the investigation, earlier notification would interfere with or jeopardize the investigation, recovery of an overpayment or imposition of a sanction. (History: Sec. 53-6-111 and 53-6-113, MCA; IMP, Sec. 53-2-201, 53-6-101, 53-6-111 and 53-6-113, MCA; NEW, 1980 MAR p. 1619, Eff. 6/13/80; AMD, 1997 MAR p. 474, Eff. 3/11/97; TRANS, from SRS, 2000 MAR p. 479.)

37.85.513 SUSPENSION OR WITHHOLDING OF PAYMENTS PENDING FINAL DETERMINATION (1) Where the department has notified a provider of a violation or an overpayment pursuant to ARM 37.85.512 the department may withhold payments on pending and subsequently received claims in an amount reasonably calculated to approximate the amounts in question or may suspend payments pending a final determination.

(2) Where the department intends to withhold or suspend payments it shall notify the provider in writing at least 10 days prior to commencement of withholding and shall include a statement of the provider's right to request an informal reconsideration of such decision as provided in ARM 37.5.305. This rule does not require that an informal reconsideration or any hearing be conducted prior to the withholding or suspension of payments.

(3) Where the department has terminated or suspended a provider, the provider shall be eligible to bill for covered services for the period covered by the suspension or termination if an appeal is decided in the provider's favor. (History: Sec. 53-2-201, 53-2-803, 53-4-111, 53-6-111 and 53-6-113, MCA; IMP, Sec. 53-2-306, 53-2-801, 53-4-112 and 53-6-111, MCA; NEW, 1980 MAR p. 1619, Eff. 6/13/80; AMD, 1984 MAR p. 1639, Eff. 11/16/84; TRANS & AMD, from SRS, 2000 MAR p. 1653, Eff. 6/30/00.)